

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

9 9 — 1 6

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

~~October 1, 1999~~  
November 1, 1999

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.252(b)

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ 152,045,735  
b. FFY 2001 \$ NA

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pp 2a, 2b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, pp 2a, 2b

10. SUBJECT OF AMENDMENT:

updates dates for the affected  
~~To establish the annual expenditure levels for~~ special outpatient indigent pools for FY  
2000

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

James K. Haveman, Jr.

14. TITLE:

Director

15. DATE SUBMITTED:

12-28-99

16. RETURN TO:

Michigan Department of Community Health  
Medical Services Administration  
P.O. Box 30479  
Lansing, MI 48909-7979

Attn.: N. Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

1/5/00

18. DATE APPROVED:

6/6/01

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

11-1-99

20. SIGNATURE OF REGIONAL OFFICIAL:

*Cheryl A. Harris*

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator  
Division of Medicaid and Children's Health

23. REMARKS:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State Michigan**  
**POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES**  
**(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

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A. Children's Outpatient Hospital Adjustor Pool

Qualifying children's hospitals will share in an annual outpatient adjustor pool of \$695,000.

Eligibility for the pool is restricted to freestanding children's hospitals that have incurred outpatient charges in excess of \$40 million for hospital fiscal years ending in the second previous state fiscal year. Payments will be made only to hospitals that have accepted cost reports on file with the Medical Services Administration by August 31<sup>st</sup> of the state fiscal year previous to the one in which the payment is made. These data have been subject to review and appeal and will not be changed.

The pool of up to \$695,000 will be distributed to eligible freestanding children's hospitals based on payments for services provided during the second previous state fiscal year (excluding special indigent pool payments). Each eligible hospital will share in the pool proportionately using the ratio of the hospital's Title XIX outpatient charges (updated for inflation to common point in time) to the sum of the Title XIX outpatient charges for all qualifying hospitals.

B. Public Outpatient Hospital Adjustor Pool

Qualifying public hospitals will share in an annual outpatient adjustor pool of up to \$350 million.

Eligibility for the pool is restricted to public hospitals with outpatient indigent volume of at least 32% and that have incurred outpatient indigent charges of at least \$35 million for hospital fiscal years ending in the second previous state fiscal year. Payments will be made only to hospitals that have accepted cost reports on file with the Medical Services Administration by August 31<sup>st</sup> of the state fiscal year previous to the one in which the payment is made. These data have been subject to review and appeal and will not be changed.

The pool of up to \$350 million will be distributed to eligible public hospitals based on payments for services provided during the second previous state fiscal year (excluding the special indigent pool payments). Each eligible hospital will share in the pool proportionately using the ratio of the hospital's Title XIX outpatient charges (updated

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TN No. 99-16      Approval                           Effective Date 11/1/99

Supersedes

TN No. 99-08 ~~08~~ *pu N. Bishop MDH*  
*5/18/01*

**RECEIVED**

**MAY 18 2001**

**DMCH - MI/MN/WI**

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**State Michigan**  
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for inflation to a common point in time) to the sum of Title XIX outpatient charges for all qualifying hospitals.

For purposes of the pools described above, the outpatient hospital charge limit is applied in the invoice processing system. Each outpatient claim is reimbursed the lesser of the fee screen based payments or actual charges. Claim line reimbursement in the invoice processing system does not include any special indigent pool payments; these are made in a separate payment.

The Medicaid outpatient payment by subprovider is limited to a maximum of the Medicaid costs for that subprovider. The cost limit test is applied to all payments, excluding any special indigent pool payments.

Medicaid outpatient hospital reimbursement to any single hospital will be allowed to exceed the hospital's Medicaid outpatient charges and the Medicaid payment may exceed a hospital's outpatient cost. The special indigent payments made under this provision will be exempt from the outpatient hospital charge and cost limits.

Aggregate Medicaid reimbursement to Michigan outpatient hospitals (including the special indigent pools) will not be allowed to exceed the federally imposed upper limit for outpatient services, including physician services, provided to Michigan recipients. To correct for differing hospital fiscal year end dates, this test will be made based on hospital fiscal years ending in the second previous state fiscal year updated for inflation to a common point in time. If the upper limit is exceeded, the size of the special indigent pool will be reduced by the amount in excess of the upper limit. If the upper limit test supports the claim that Medicaid's total payment is less than what the Medicare payment would have been for comparable services under comparable circumstances, the amount up to the upper limit may be dispersed to the qualifying hospitals.

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**TN No.** 99-16

**Approval** \_\_\_\_\_

**Effective Date** 11/1/99

**Supersedes**

**TN No.** 99-05

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